Commonwealth of Massachusetts
Executive Office Health and Human Services

RY2022 EOHHS Manual Release Notes (Version 15.1)

Supplement to:
RY2022 EOHHS Technical Specifications Manual for Acute Hospital Quality Measures (v15.0)

Published: August 25, 2021

Introduction

A. Purpose

The EOHHS Release Notes provide hospitals with interim updates on MassHealth Acute Hospital Pay-for-Performance (P4P) Program quality data collection and reporting requirements applicable to the current rate year EOHHS Technical Specifications Manual content posted on Mass.Gov website.

1) **Important Update:** MassHealth has extended the reporting deadline for the new harmonized care coordination measure set (CCM-1, 2, 3) data specifications to begin with CY2022 that will apply to RY2023 incentive payments. The MassHealth CCM data specifications were modified to harmonize with the CMS-IPFQR care transition measures and the Joint Commission standards based on stakeholder consensus. Adjusted specifications apply to the broader initial patient population described in Section 2.B of EOHHS Technical Specifications Manual (15.0).

2) **Changes to Data Specifications:**
   a) **Reconciled Medication List (CCM-1)**: Require that each medication include an intended duration or an indication to continue medication until told to stop.

   b) **Transition Record Received with Specified Data Elements (CCM-2):** Update **a**dvance care plan data element definition. Remove reference to DNR and full code status to meet measure.

   c) **Timely Transmittal of Transition Record (CCM-3):** Add new patient refusal data element. If there is documentation that the patient or caregiver refused transmission the case will be excluded.

3) **Effective Date:** The updated timeline for new CCM-1, 2, 3 data specifications reporting will begin with Q1-2022 discharges (1/01/2022 – 3/31/2022) for the August 2023 submission cycle. The reporting deadline extension provides hospitals and vendors ample time for implementing data collection and reporting systems

B. EOHHS Manual Versions. The Release Notes version 15.1 document should be used in conjunction with the RY2022 EOHHS Technical Specifications Manual (v15.0). Hospitals are responsible for downloading and using the appropriate versions of EOHHS Manual and Appendix data tools that apply to each quarterly data period being collected and submitted. Failure to adhere to appropriate versions of data collection tools will result in MassQEX portal rejecting data files.

C. Release Notes Guideline. Updates in the EOHHS Release Notes are organized to supplement the EOHHS Manual table of content core sections and appendices using the following headings**:**

1) **Key Impact** – identifies the EOHHS manual section that is impacted by the change listed (i.e.: measure specifications, data tools, dictionary, etc.). A key impact is defined as information that will substantively affect data collection and reporting file requirements.

2) **Description of Change** – identifies the specific content within the manual section where the change was made. (i.e.: measure specifications, flowcharts, data format, reporting values, etc.).

3) **Rationale** – a brief statement on the reason why the change was made.

Contact MassQEX Helpdesk at massqexhelp@telligen.com if have any questions about the contents of this Release Notes document.

Section I: Changes in Release Notes (v 15.1)

This section summarizes the key impact, description of change and rationale for the updated requirements.

A. Measure Specifications. Changes to CCM-1, 2, 3 reporting specifications are summarized below.

Table A – Changes to Data Reporting Specifications

Key Impact	Description of Change	Rationale
Section 3.C.3: Transmission of Transition Record Flowchart	• Update CCM-3: Modify flowchart to add data element "Patient Refusal of Transmission". Value of YES yields exclusion to CCM 3 measure. Value of NO yields continue to Transmission Date data element.	• Harmonize specification with the Joint Commission requirements on patient rights to privacy.
Section 6.B Data Validation Scoring	• Update Table 6.1 scored elements for validation See Section III of this document.	• Clarify new data validation scored elements.
Appendix A-3: Data Abstraction tool	• Update CCM-3: Addition of question "Is there documentation in the medical record of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care?". This will be inserted as Question 28.	• Clarify abstraction tool questions to capture new patient refusal specification.
Appendix A-4: XML Schema MassHealth Specific File	• Update CCM-3: Addition of Patient Refusal of Transmission data element and field requirements.	• Ensure new patient refusal data element is added to file requirement.
Appendix A-6: MassHealth Data Dictionary	• Update CCM-1: Reconciled Medication List to require duration for all medications or a blanket statement indicating that the patient should continue the medications until told to stop. • Update CCM-2: Change advance care plan (ACP) data element definition to remove DNR and Code Status from allowable values. • Update CCM-3 Add new Patient Refusal of Transmission data element definition.	• CCM-1: Harmonize definition with CMS-IPFQR care transition record current medication list data element. • CCM-2: Update ACP element consistent with state/federal definitions. Harmonize element with CMS-IPFQR definition as applicable to broader medical/surgical patient population. • CCM-3: Clarify definition applicable to the MassHealth measure.
Appendix A-7: MassHealth Measure Calculation Rules	• Update CCM-3 rules: Insert new row 16 for Patient Refusal of Transmission. Calculation rule states "If value = Y, assign to Category B/ assign to Category X if missing or no match"	Ensure evaluation of patient refusal data element is reflected in measure calculation rules

B. Appendix Tool Versions: Updates to Table 2.4 specific data tool versions in EOHHS Manual (v15.0) applicable to harmonized CCM-1, 2, 3 quarter reporting is summarized below.

Table B: Additional Changes in CCM Data Tool Versions

Appendix	Data Tool Name	Q1-2022 discharges	Q2-2022 discharges	Q3-2022 discharges
A-3	Data Abstraction Tool (CCM-1,2,3)	v15.1	v15.1	v15.1
A-4	XML Schema MassHealth Specific Files	v15.1	v15.1	v15.1
A-6	MassHealth Data Dictionary	v15.1	v15.1	v15.1
A-7	Measure Calculation Rules	v15.1	v15.1	v15.1

Contact the MassQEX Help Desk massqexhelp@telligen.com or (844) 546-1343 for all questions regarding upcoming changes to care coordination data reporting specifications.

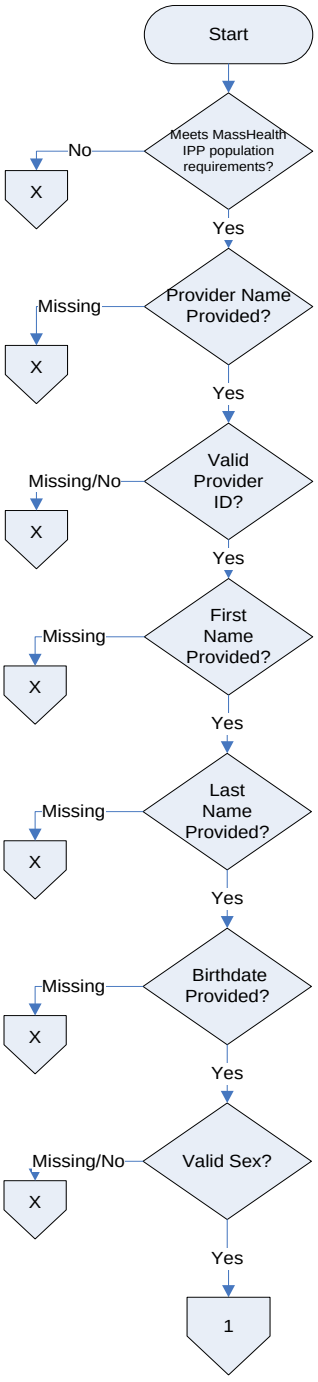
Section II: Updates to Measure Description Flowcharts

A. Section 3.C-3: Timely Transmittal of Transition Record Measure Flowchart

Care Coordination Measure (CCM-3)

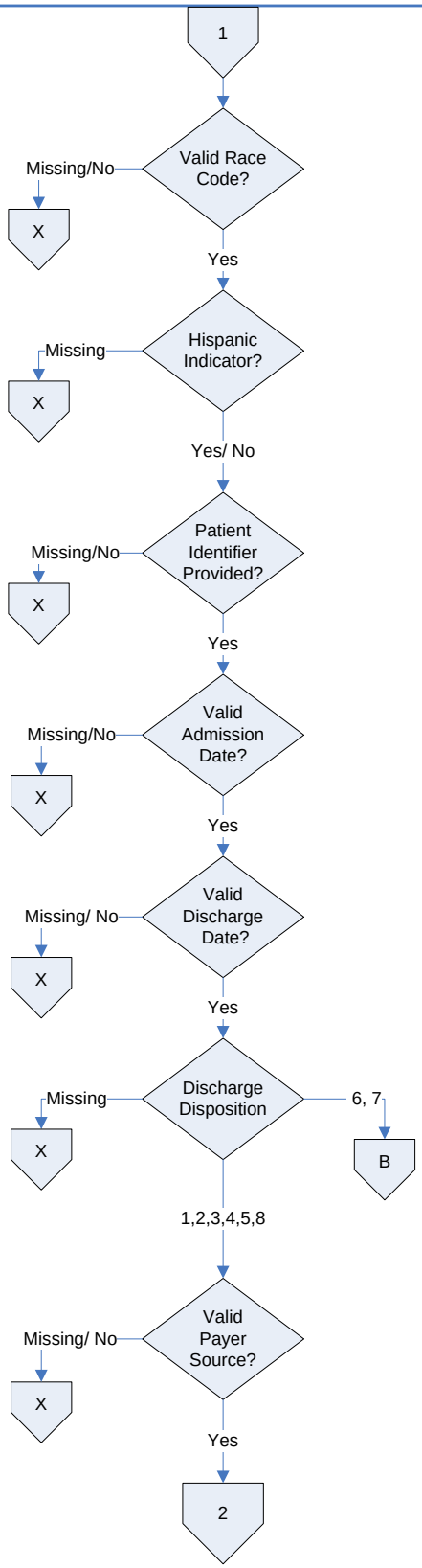
***Numerator:** Patients for whom a written transition record was transmitted to the facility or primary physician or other health care professional designated for follow up care within 2 days of discharge

***Denominator:** Patients discharged from an inpatient facility to home/ self care or any other site of care.

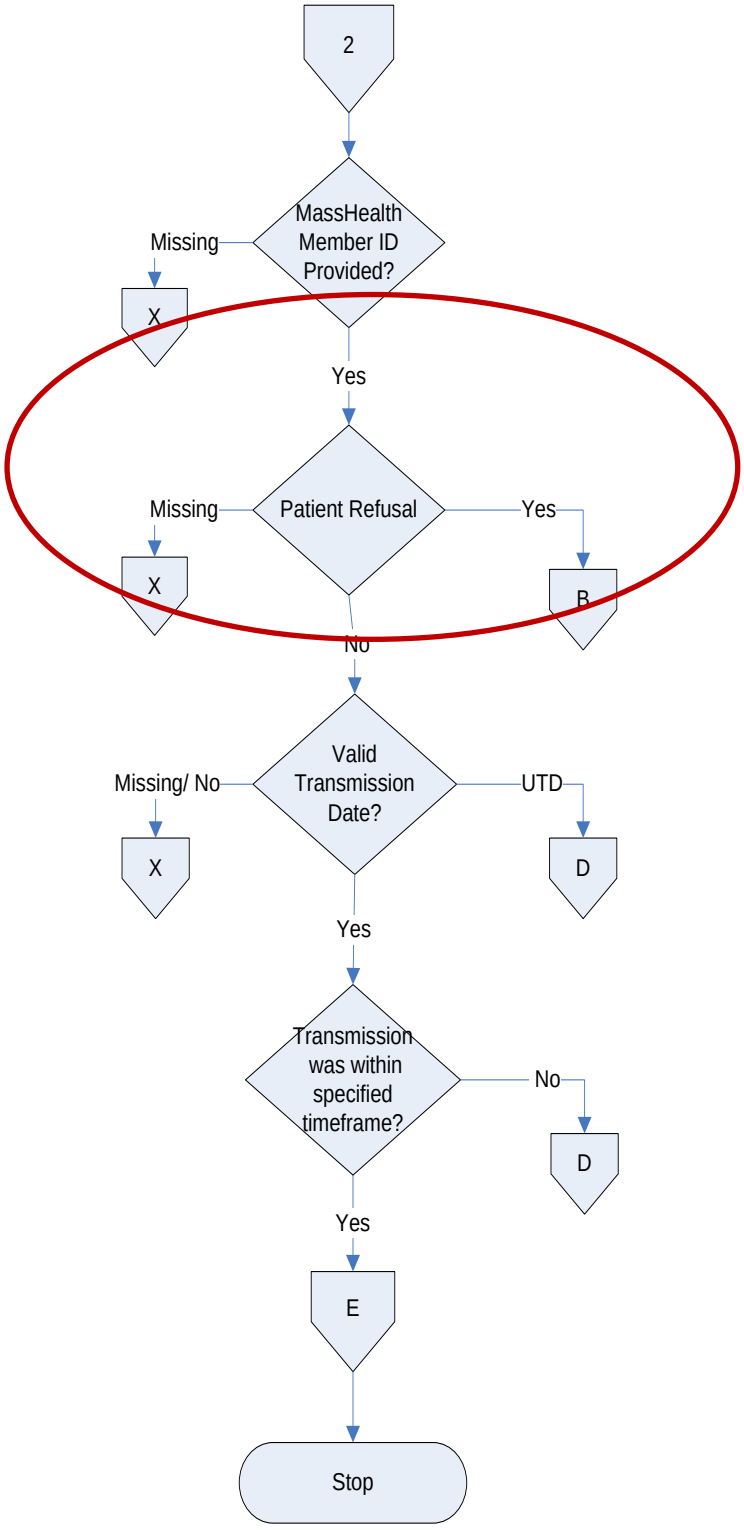


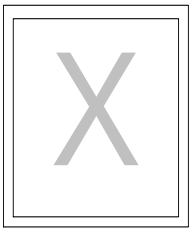
CCM-3 Flowchart (Continued)

Care Coordination Measure (CCM-3)

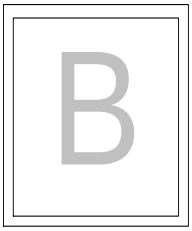


CCM-3 Flowchart (Continued)

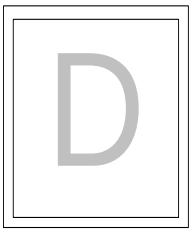




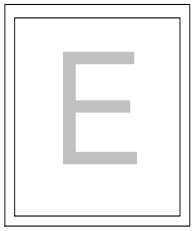
Review Ended
Not in Measure Population
Missing or Invalid Data
Case will be Rejected



Review Ended
Not in Measure Population
Excluded from Numerator and Denominator



Review Ended
In Measure Population
Excluded from Numerator
Included in Denominator



Measure Met
In Measure Population
Included in Numerator and Denominator

Note:
If the Transition Record was transmitted within 2 days of the discharge date, the case will be assigned to Category E.

Section III: Updates to MassHealth Data Dictionary

MassHealth Data Dictionary (Appendix A-6)

1) **Update to CCM-1:** the following excerpt to the reconciled medication list data element illustrates where changes (in italic underline) apply to the notes for abstraction:

Data Element Name: Reconciled Medication List
Collected For: CCM-1

Notes for Abstraction: Prescribed dosage, instructions, and *intended duration* must be included for each continued and new prescription and non-prescription medication.

A generalized statement regarding intended duration, such as a blanket statement indicating that the patient should continue the medications until told to stop, would be acceptable for routine medications.

2) **Update to CCM-2:** the following excerpt to the advance care plan data element illustrates where text is removed (underline strikethrough) in the definition, notes for abstraction, and guidelines for abstraction table**.**

Data Element Name: Advance Care Plan
Collected For: CCM-2

Definition: An Advance Care Plan refers to a written statement of patient instructions or wishes regarding future use of life sustaining medical treatment. An Advance Care Plan may include: an advance directive, living will, healthcare proxy or surrogate decision maker, or power of attorney. *(Reference to DNR was removed)*

Notes for Abstraction: The presence of an advance care plan must be documented on the transition record for all patients 18 years and over.

A checkbox or documentation of the presence of an advance directive, health care proxy, surrogate decision maker, power of attorney, etc. must be documented. *(Reference to DNR or full code status was removed)*

Guidelines for Abstraction:
Reference to "Do Not Resuscitate (DNR) and Documentation of code status (Full Code)" were removed from the abstraction guidelines table inclusion column shown below.

Inclusion	Exclusion
Advance Directive Power of Attorney Health care proxy Living Will Medical Orders for Life-Sustaining Treatment (MOLST)	Patients < 18 years of age *Do Not Resuscitate – DNR etc.* *Documentation of code status: Full Code*

3) **Update to CCM-3:** the full definition of the new patient refusal data element follows.

Data Element Name:	**Patient Refusal of Transmission**
Collected For:	CCM-3
Definition:	Documentation in the medical record of the patient's or caregiver's refusal of transmission of the patient's healthcare information to include the Transition Record to the next site of care, physician, or other health care professional designated for follow-up care.
Suggested Data Collection Question:	Is there documentation in the medical record of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care?
Format:	**Length:** 1 **Type:** Alphanumeric **Occurs:** 1
Allowable Values:	Y (Yes) The medical record includes documentation of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care. N (No) The medical record does not include documentation of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care.
Notes for Abstraction:	Patient refusal of transmission of the transition record may occur at any point during the inpatient stay. Documentation requirements may be met by the following: • patient signature indicating refusal of transfer of medical record information • nursing note stating patient refusal • other health care provider documentation of refusal -TRANSFER- In the event the patient is transferred to another site of care where the plan for follow-up care will be determined at the time of discharge from that site, patient refusal is abstracted as No. The discharge date should be used as the Transmission Date. Documentation of the discharge date also applies to patients discharged and admitted within the same site.
Suggested Data Sources:	Admission Consent Forms Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Section IV: Updates to Data Validation Scored Elements

1) **Data Element Scoring.** Updates to Table 6.1 in EOHHS Manual (15.0) that apply to the calculation of the overall validation rate for the harmonized care coordination measures data reporting as of Q1-2022 are summarized in the following table.

Table 6-1: Summary of Data Element Scoring Categories

Scored Data Elements	Non-Scored Data Elements
NEWB-1 Measure: Admission to the NICU, Discharge Disposition, Exclusive Breast Milk Feeding, Term Newborn, Race, Hispanic Indicator **MAT-4 Measure**: Gestational Age, Previous Live Births, Race, Hispanic Indicator **CCM Measures**: Discharge Disposition, Reconciled Medication List, Transition Record, Advance Care Plan, Contact Information 24 hours/ 7 days, Contract Information for Studies Pending, Current Medication List, Discharge Diagnosis, Medical Procedures and Tests, Patient Instructions, *Patient Refusal of Transmission*, Plan for Follow-up Care, Primary Physician/ Healthcare Professional for Follow-up Care, Reason for Admission, Studies Pending at Discharge, Transmission Date, Discharge Date, Race, Hispanic Indicator	• Admission Date • Admission Time • Birth Date • Discharge Date (scored for CCM-3 only) • Discharge Disposition (scored for NEWB-1, CCM) • Episode of Care • First Name • Hospital Patient ID # • ICD-CM Diagnosis Codes • ICD-PCS Procedure Codes • Last Name • Member ID Number • Payer Source • Provider ID • Provider Name • Sex